Testimony of Eugene Vining, M.D.

for the Connecticut ENT Society

Before the Public Health Committee on

HB5308 AN ACT ESTABLISHING STANDARDS FOR CONTRACTS BETWEEN HEALTH INSURERS AND PHYSICIANS

HB6841 AN ACT CONCERNING STANDARDS IN CONTRACTS BETWEEN HEALTH INSURERS AND PHYSICIANS

February 21, 2007

Good Afternoon, Senator Handley, Representative Sayers and other distinguished members of this committee. For the record, my name is Dr. Eugene Vining, and I am an otolaryngologist practicing in a group practice in New Haven, North Haven and Branford. I am here, as past president of the CT ENT society, representing over 90% of the ENT specialists practicing in Connecticut in **support of HB5308** as written and HB 6841 with some amendments.

First and foremost, we would like to applaud the efforts of this committee for addressing this important issue concerning managed care contracting issues with physicians, especially since a bill similar in nature to HB6841 was passed last year. Last year's bill HB1589 AAC Standards in Contracting Between Physicians and Managed Care Organizations(MCOs), does many of the things that HB 6841 proposes to do including the creation of a task force to study unilateral changes which is scheduled to begin in October 2007 and provides fee disclosure of 30 CPT codes to physicians. Unfortunately, HB1589 lacked vital language which is necessary in bringing some level of fairness to the contractual arrangements between physicians and MCOs and ultimately to preserving the healthcare delivery system in Connecticut. To achieve this level of fairness we would like the committee to consider passing language which would include;

- **Full and Complete CPT Fee Schedules,** whereby fee schedules cannot be changed for the course of the contract period unless mandated by law or with mutual written agreement.
- **Prevent unilateral changes without the written agreement of the physicians.**
- **Medical Necessity to be universally defined,** not defined by each MCO, based on their interpretation of what is medically necessary.

This is not a new issue for our society or for the CT State Medical Society. The medical community has been testifying on this issue for over 5 years. I personally testified last year on HB 1589, AAC Standards in Contracting Between Physicians and Managed

Oare organizations in the insurance committee, and thought it was important for me to come back again this year and share my personal disappointment and that of the medical community, with the passing of HB1589 and to also share a personal story of how the failure of HB1589 to address the "unilateral change issue" lead me and my partners to resign from a senior contract just a month ago. First I would like to share some of the shortcomings of last year's standards in contracting bill (HB1589) in that it only gave physicians "partial fee" schedules, when we testified that full fee disclosure (complete CPT schedule) is necessary in making sound business decisions. Second, it did nothing to prevent the unilateral changes that are taking place against physicians and ultimately the patients we serve. Third, it did not give a universal definition of medical necessity, a definition which is clearly needed to prevent the manipulation and interpretation of an industry, whose primary goal is to control claim payout and refers to this payout as their "loss ratio".

I have included my testimony from last year for your review. I have also included a recent termination letter my group was forced to write after receiving notification by Anthem BC/BS of an unacceptable unilateral change to our Medicare HMO contract. If last year's bill had contained language to prevent the unilateral changing of contractual terms by MCOs instead of task force language, I would still be seeing my senior patients who signed up for benefits with Anthem BC/BS. This egregious behavior of making unilateral changes to a contract after the physician has signed up as a provider for the Managed Care Organization is hurting Connecticut residents and is creating an access problem in this state. Clearly, physicians do not want to stop seeing their patients but with no bargaining power and with no way of preventing changes to a signed contract, physicians are faced with the difficult decision of walking away from their patients.

We need fair contracts telling us how much we will be paid on each procedure and service we render and we need real contract terms which can not be modified and changed after we agree upon set terms. And finally we need a definition of medical necessity which is universally adhered to by the Managed Care Industry.

In closing, we ask you to support HB 5308 as written and consider the following amendments to HB 6841. In doing so, you will be improving patient access to healthcare services, decreasing the cost of providing services by decreasing the administrative burden of managing inconsistent insurance contracts, and you will provide physicians with the tools needed to make sound business decisions to help better run our business' and exponentially improve the balance of fairness in these physician/MCO contract arrangements.

Thank you for your time and consideration, and I will entertain any questions from members of this committee.